Wisconsin Department of Health and Family Services
Crosswalk from CMS Rate Setting Checklist to 2006 Family Care Report

Item		Location	Comments
AA.1.0	Overview of Ratesetting Methodology	Entire Report	
AA.1.1	Actuarial Certification	Pages 15-17	
AA.1.2	Projection of Expenditures	NA	DHFS will provide
AA.1.3	Procurement, Prior Approval and Ratesetting	NA	
AA.1.5	Risk contracts	NA	
AA.1.6	Limit on Payment to other providers	NA	
AA.1.7	Rate Modifications	NA	
AA.2.0	Base Year Utilization and Cost Data	Pages 4-10	
AA.2.1	Medicaid Eligibles under the Contract	NA	
AA.2.2	Dual Eligibles	NA	
AA.2.3	Spenddown	NA	
AA.2.4	State Plan Services only	NA	
AA.2.5	Services that may be covered out of contract savings	NA	
AA.3.0	Adjustments to Base Year Data	Pages 9-10, 13-14	
AA.3.1	Benefit Differences	NA	No Changes in Benefits
AA.3.2	Administrative Cost Allowance Calculations	Page 13	Exhibit III-1
AA.3.3	Special Populations' Adjustments	NA	
AA.3.4	Eligibility Adjustments	NA	
AA.3.5	DSH Payments	NA	
AA.3.6	Third Party Liability	NA	
AA.3.7	Copayments, Coinsurance and Deductibles in Capitated Rates	Page 13	Exhibit III-1
AA.3.8	Graduate Medical Education	NA	
AA.3.9	FQHC and RHC Reimbursement	NA	
AA.3.10	Medical Cost / Trend Inflation	Pages 11-13	Exhibits II-2A, 2B, 2C & Exhibits II-3A, 3B, 3C
AA.3.11	Utilization Adjustments	Page 10	
AA.3.12	Utilization and Cost Assumptions	Pages 11-12	
AA.3.13	Post-Eligibility Treatment of Income	NA	
AA.3.14	Incomplete Data Adjustment	Pages 5, 13	
AA.4.0	Establish Rate Category Groupings	Pages 1-2	Exhibit III-1
AA.4.1	Age	NA	
AA.4.2	Gender	NA	
AA.4.3	Locality / Region	Page 1	Exhibit III-1
AA.4.4	Eligibility Categories	Page 1	Exhibit II-4 & Exhibit III-1
AA.5.0	Data Smoothing	Page 8	
AA 5.1	Special Population and Assesment of the Data for Distortions	NA	
AA.5.2	Cost-neutral data smoothing adjustment	NA	
AA.5.3	Risk Adjustment	Pages 5-10	
AA.6.0	Stop Loss, Reinsurance or Risk Sharing arrangements	NA	
AA.6.1	Commercial Reinsurance	NA	
AA.6.2	Simple stop loss program	NA	
AA.6.3	Risk corridor program	NA	
AA.7.0	Incentive Arrangements	NA	

Wisconsin Department of Health and Family Services

Calendar Year 2006 Family Care Capitation Rates

Prepared by:

PricewaterhouseCoopers

January 2006

TABLE OF CONTENTS

SUMMARY OF EXHIBITS

I. EXECUTIVE SUMMARY

This report describes the methodology used to develop monthly capitation payments for Family Care for Calendar Year 2006. This program is sponsored by the State of Wisconsin Department of Health and Family Services and covers long-term care (LTC) services previously provided through the Medicaid State Plan, the Medicaid Home and Community Based Waivers (Waiver), and the Community Options Program (COP). Primary and acute medical services are not covered by Family Care; these services continue to be provided in the Medicaid fee-for-service environment and by the Wisconsin Partnership Program.

Rates are calculated for the Comprehensive and Intermediate populations. Furthermore the Comprehensive rates are separately developed for the five participating CMOs: Fond du Lac, La Crosse, Milwaukee, Portage, and Richland. The rates are based on CMO specific encounter data, with adjustments for variation in functional status as measured by each recipient's Long-Term Care Functional Screen (LTCFS). Baseline experience data is adjusted for trend, recognizing changes in utilization, cost, technology and functional status that are expected between the 2004 data period and the 2006 contract period. An allowance is also made for administrative costs, and the claims data is adjusted to account for incomplete claims.

Functional Status Model

The rates are based on a regression model of functional status developed from CMO-reported experience for calendar year 2004. Regression is a statistical technique that produces an estimate of the effect of each factor individually on the cost for an individual. The final model uses the following "functional" measures to develop the capitation rates:

- County
- SNF level of care for the elderly
- Type of developmental disability for the disabled, if any
- Number of IADLs
- ADLs and their levels of help
- Interaction terms among various ADLs
- Behavioral indicators
- Medication management

The county values from the regression model recognize county-to-county cost differences that are not explained by the other factors in the model. Variation in county experience results from differences in provider fee levels, resource availability, potentially incomplete data, CMO management and other factors. Although the regression model yields county parameters, there remains a material difference in the per member per month costs among counties that is not fully explained by that model. Consequently, we blended the results of the regression model with measures of differences in costs by geography for a market basket of LTC services.

Trend rates are developed based on an analysis of fee-for-service claims experience for the Elderly and Disabled populations, and take into account a one percentage point increase in the portion of the population that is in the Disabled category. This cohort has a per capita cost that is roughly twice as high as that of the Old Age Assistance cohort, thereby increasing the average trend rate by 2%. Specifically, the Disabled population now makes up 61% of the total population compared to the prior level of 60%.

Separate trend rates are developed for the Disabled and Elderly population groups and are then combined to a weighted average. For the two year trend period we have calculated and applied an annualized rate of 3.1%, for a total trend of 6.2%. Because there have been no changes in provider reimbursement rates, this trend relates to utilization and case mix changes only.

An additional adjustment was made to the rates to account for MA-specific cost sharing. Finally, the rates include an allowance for health plan administrative expense and reasonable profit levels.

Disclaimer

In performing this analysis, we relied on data and other information provided by the State. We have not audited or verified this data or other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and believe the data appear to be reasonable for this rate development. If there are material errors or omissions in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Differences between our projections and actual results depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis.

This report is intended to assist the State in developing Family Care capitation rates. It may not be appropriate for other uses. PricewaterhouseCoopers does not intend to benefit and assumes no duty or liability to other parties who receive this work. This report should only be reviewed in its entirety. It assumes the reader is familiar with Family Care, the Wisconsin Medicaid long-term care and Waiver programs, and managed care rating principles.

The results in this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely upon these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

II. FUNCTIONAL SCREEN METHODOLOGY

This section of the report details the development and statistical validity of a risk adjustment methodology appropriate to meet the State's needs and comply with CMS requirements as specified in its checklist titled "The Financial Review Documentation for At-Risk Capitated Contracts Ratesetting."

To appropriately reflect the relative risk of enrollees in the Family Care program, a regression model was developed that measures differences in utilization of services based on functional status. A Family Care-specific model was developed because available risk assessment and risk adjustment models were deemed to be a poor fit for measuring differences in expected Long Term Care costs among enrollees. Available models are largely designed to estimate the need for acute care services, and do not take into account such factors as frailty and the need for assistance with activities of daily living. Through use of a regression model we are able to measure the independent and combined effects of specific cost drivers for the services and population covered by this program.

Data Preparation

Managed care eligibility and claims experience data from the five Wisconsin CMOs for calendar year 2004 is used to establish baseline costs for the rate development. In addition to claims and eligibility data, exposure and functional screen data were provided by the State. Each recipient's cost for 2004 was matched to their corresponding eligible days. Cost PMPM was determined as the total payments divided by total eligibility days times 30.41667 (the average number of days in a month).

To run a regression model, it is essential that all data fields are populated. To correct for missing data, we used certain decision rules. Specifically, where gender is missing from the eligibility or claims file, the recipient is assumed to be female; however, gender is not a rating variable. For elements of the functional screen, missing values were assumed to have a value of "0". In other words, we assumed that the individual did not have the characteristic addressed by the question unless it was affirmatively reported.

Claims Experience

Aggregate 2004 claims used for the statistical analysis are $187,580,165, and the exposure months total 99,317, resulting in a PMPM of $1,888.71 for the Medical Assistance (MA) comprehensive population. Exhibit I-1A shows this experience by county, target group, and category of service (Exhibit I-1B shows this experience when the non-MA and non-comprehensive are included). Based on discussions with DHFS staff, we understand that reported costs are prior to any third party liability or participant cost sharing.

The claims data covers dates of service for calendar year 2004 with run out through August 2005. These data must be adjusted to reflect claims that were Incurred But Not Reported (IBNR) in order to "complete" the starting claims database. IBNR adjustments are made by CMO: Fond du Lac data was increased by 0.04%, La Crosse by 0.11%, Milwaukee by 0.87%, Portage by 0.03%, and Richland by 0.01%. IBNR claims have been estimated using standard actuarial methods.

The remainder of this section summarizes the methodology used to develop the proposed payment rates. The results include the regression analysis conducted on the CMO calendar year 2004 encounter data and the functional measures reported from the screens conducted by the Resource Centers and CMOs.

Sample Size and 2005 Model Validation

There were 10,281 MA Comprehensive enrollees in the Family Care program during 2004 that had eligible claims during the year. The experience of this entire population is used for designing the risk adjustment methodology, except for that portion of the population described in the section titled "Carve-Outs," below.

Using the 2004 data, an analysis was performed to validate the statistical significance of the variables used in the prior year's model. The results showed that the variables included in the prior model were appropriate, and the same variables were retained in the current model; the parameter values were calibrated to match the most recent experience.

Carve-Outs

Any recipients that were not eligible for Medical Assistance and those not eligible for comprehensive care were excluded from the risk adjustment and rate setting process. These groups constituted less than 5% of the Family Care population in 2004. Rates are separately developed for non-MA and non-comprehensive recipients.

Functional Status Information

All recipients were given health status and functional screens annually prior to July 1, 2004 or at the point of Family Care enrollment during 2004. Such information is readily available on the

State's administrative system and is expected to continue to be available while the Family Care program is in effect.

The health status and functional screens collect the following information on recipients:

- Type of living situation, level of care (e.g., skilled nursing)
- The presence of a developmental disability
- The level of assistance for each instrumental activity of daily living (i.e., IADLs)
- The level of assistance for each activity of daily living (i.e., ADLs)
- The presence of one of 64 diagnoses groups allocated into 10 diagnostic classes
- The use of medications and the level of assistance required to correctly administer them
- The frequency of certain health related services (e.g., pain management, TPN, dialysis, etc.)
- The levels of communication, memory, and cognition
- The presence and extent of certain behaviors (wandering, self-injurious, offensive, etc.)

Legal and administrative information is also collected but not used for risk adjuster development.

All screeners are trained by the State to ensure that the screens are administered consistently.

Approach to Rate Development

Estimated costs PMPM are determined for recipients based on each recipient's IADL count, specific levels of ADL assistance needed, the presence of certain behavioral problems, detail on medication assistance provided, the level of care provided, the type of developmental disability (if any), certain combinations of ADLs, and geographic region. Monthly screen information of the cost period (calendar year 2004) is used, resulting in a concurrent risk adjustment model.[1]

[1] Note: risk adjustment models are typically termed "concurrent" or "prospective". A concurrent model measures expected costs in the current period based on claims and screening data for the current period. A prospective model measures expected costs in a subsequent period based on claims and screening data for a current period. The choice of whether to use a concurrent or prospective model depends on a number of factors, including the stability of the population. For the Family Care population, we believe a concurrent model is appropriate, although a prospective

Linear least squares regression was used to model the effects of the above factors in predicting costs PMPM. The overall cost estimate for a recipient is determined by summing the coefficients for the factors applicable to the recipient, and adding the regression intercept. This method essentially results in an individual rate for each recipient rather than categorizing them into mutually exclusive groups, as would be done with other approaches to rate development.

Exhibit I-2 shows the results of the regression analysis. The R-squared of the risk adjustment model is close to 40%. This value is similar to, but somewhat higher than the R-squared value for many concurrent physical health models. This high predictive power results in part from use of a concurrent model, and from the fact that use of LTC services is more persistent on average than use of acute health care services.

When used with the 2004 functional status indices, the regression model estimates a baseline cost by CMO for 2004. To better assess the prospective cost in a county, we used the functional screens active in October 2005 for the Family Care population enrolled in each county in 2004. This risk adjustment technique is discussed in further detail later in the report.

model is not expected to yield materially different results for this program, given the limited turn-over of the population.

Regression Modeling - Details

Using calendar year 2004 MA Comprehensive data, an ordinary least squares linear regression model is created to relate monthly costs to recipient functional characteristics. The unit of analysis is the recipient month. That is, the monthly 2004 cost and the recipient's corresponding functional screen constitute one observation.

The statistical analyses weigh experience in proportion to each recipient's days of eligibility. Furthermore, to improve the fit of the model we have excluded claims that constitute the highest lowest 0.5% of all monthly recipients based on cost.

Modeling proceeds in a stepwise manner, starting with variables that explain the most variation and incrementally adding variables that have a marginally decreasing effect on improving the model's R-squared value and increasing the model's overall predictive capacity. The county variables are included at each step. Note also that all predictor variables are coded as binary, (i.e., having a value of "0" or "1".) Thus, a recipient either has a particular characteristic or they do not. With this approach we avoid forcing a relationship upon the variables, such as doubling the expected costs for an individual with twice as many ADLs as another individual.

When considering variables to include in the model, we used the following criteria:

- Variables are included in the model if they show a 5% level of significance.
- Variables are excluded if, when included, multicollinearity is present. That is, when an additional variable is included it shows a strong linear relationship among one or more of the other variables.
- Variables are excluded to simplify the model if including them only marginally increases model fit.

With a baseline model established, the effects of interaction are considered. Interaction terms are important since the effect of, for example, a bathing ADL requiring assistance with a dressing ADL requiring assistance, may be greater or less than the sum of these effects modeled individually.

The final regression model consists of twenty five variables to predict cost. The variables are separated into the following seven classes: region, level of care, IADLs, specific ADLs, interactions, behavioral, and medication use. The estimated impact on the cost for each variable is shown along with its significance (i.e., p-value), relative contribution in explaining the variation (i.e., Incremental Partial R^2) and the proportion of the population with the characteristic.

Exhibit I-2 shows the final statistical model. The model explains approximately 40% of the variation in the data. The model has a mean of $1,841 PMPM (due to excluding the highest and lowest cost individuals) versus an actual $1,888 PMPM. Note that when the model is applied, the values are normalized to $1,888, prior to adjustment for IBNR.

The average effect of each variable shows how the aggregate cost PMPM are allocated among individual characteristics in the population. For example, the model attributes $84 PMPM of the aggregate PMPM ($1,841) to IADL-5. Thus to derive the average PMPM cost for a given population, one would cross multiply all regression parameter estimates by the proportion of the population with the respective characteristic.

County Factors

The county values developed by the regression represent differences in costs by county that are not explained by other variables in the model. The county estimates represent differences due to historical costs by count, and can result from a variety of factors, including CMO management, provider fee levels, resource availability, potentially incomplete data and others. The intent of using the county experience factors is to recognize differences in costs that cannot be explained directly by the regression model, and to provide stability to funding for the Family Care program.

The State separately developed factors based on the relative wage levels and fees paid in the five CMO counties. They used wage data collected by the State / Federal government, and reported by the U.S. Bureau of Labor Statistics, for occupations involved in providing care: registered nurses, social workers, home health aides, personal care / home care aides and personal care / service. Average fees paid by Medicaid for nursing home and residential care days were also reviewed. The relative wage and fee levels were aggregated using the relative costs for these services for all CMOs combined. This process estimates the potential costs faced by the CMOs.

We averaged these relative values with the county factors from the regression model. In comparing with the prior year's factors, we imposed a limit on change of the county factors to plus/minus 1% from year to year to moderate the yearly change. The table below shows the combined effects of this adjustment.

Family Care
County Effect Adjustment

	Regression Values PMPM	Adjusted Values PMPM
Fond du Lac	**($264.66)**	**($168.65)**
La Crosse	**(47.98)**	**(176.05)**
Milwaukee	**0.00**	**55.49**
Portage	**82.45**	**(148.90)**
Richland	**(60.01)**	**(35,46)**
Composite	**(31.93)**	**(28.80)**

All adjusted values shown except Milwaukee are negative, since Milwaukee was used as the base in the regression model and is the highest cost county. The $3.07 PMPM increase in the composite county factor due to rounding requires a downward 1% adjustment so that the final model matches the overall mean.

Application of the Model

The regression model was developed using 2004 cost and functional screen data. To determine expected costs for the contract period, we obtained updated functional screen information as of October 2005. This October 2005 data was applied to the regression coefficients to derive cost relativities between each of the CMOs. The relativity factors were calculated using the expected cost PMPM by county at October 2005. Exhibit I-3 shows the distribution of the population by CMO and functional measure used to calculate the final base rates.

Using October 2005 functional screen data provides a snapshot of the estimated average cost for each of the counties at a point in time. The estimated costs only measure a change in the proportion of individuals with a given characteristic from the two periods: calendar year 2004 and October of 2005. As a result, using the updated functional screen data does not have a direct impact on the aggregate baseline costs. This approach quantifies a relative change in acuity between the plans, and thus shifts expected costs among counties. The most recent functional screen information is used to better assess the relative prospective cost in a county.

III. FEE-FOR-SERVICE TREND DEVELOPMENT

Trend rates are used to project the 2004 baseline cost data beyond the base cost period to the 2006 contract period.

The two-year trend of 6.2% (3.1% annually) was developed using FFS Medicaid Management Information System (MMIS) and Human Services Reporting System (HSRS) claim and eligibility data from calendar years 2000 through 2004. The trend over this period includes annual mix and utilization trend, as well as annual reimbursement increases. To isolate the trend associated with utilization and mix, the fee increases were backed out of the historical PMPM values. To derive final trend rates, the mix / utilization component is adjusted for estimated fee increases over calendar years 2005 and 2006. However, because no fee increases were provided to FFS or HCBW providers in the State's biennial budget, the final trend rate assumes no fee increases in 2005 and 2006.

Exhibit II-1 shows the eligible days for each year from 2000 to 2004 for both the Elderly and Disabled fee-for-service populations. The proportion of the population that is Disabled has remained flat or increased each year since 2000 (except 2002) for both MMIS and HSRS eligibility.

The following table illustrates the development of the trend by each population cohort.

	Elderly Population Only	Disabled Population Only	Total Population
Trend from CY04 to CY05	**4.8%**	**2.1%**	**3.1%**
Trend from CY05 to CY06	**4.9%**	**2.1%**	**3.1%**
Trend from CY04 to CY06	**9.9%**	**4.2%**	**6.2%**

The total population trend accounts for both the change in costs within each population and the change in the mix of eligibles by population.

Exhibits II-2A, II-2B, and II-2C contain the development of the projected annual trends from 2004 to 2006 for the Total, Elderly, and Disabled comprehensive populations, respectively.

Exhibits II-3A, II-3B, and II-3C summarize the comprehensive per member per month (PMPM) costs and average annual trends from 2000 to 2004 for the Total, Elderly, and Disabled populations, respectively. The trends are based on experience from non-Family Care counties only.

Exhibit II-4 shows the Intermediate rate for 2006. At this time there are very few recipients in this rate category. Based on the limited data available, the 2005 Intermediate rate appears to be sufficient for covering CMO Intermediate costs. Consequently, the rates from the prior year have been used.

IV. FINAL RATE METHODOLOGY

In summary, the 2006 rates were developed as described below.

1. Determine functional status based costs using the 2004 CMO reported experience and functional screens from as outlined in Section II. These cost estimates are adjusted to reflect the following:

   a. An estimate for IBNR using payments through August 2005,

   b. The difference between the eligible months and claims used in the regression analysis versus the actual total claims including the outliers and recoveries and eligible months for all participants including those who had no eligible claims in 2004 and those with outlying claims. Outlier claims are the 0.5% highest and 0.5% lowest monthly cost recipients excluded from the regression analysis in order to improve the fit. The outlier claim adjustment was based on a blend of a uniform adjustment to all CMOs and an adjustment based on CMO specific experience.

2. Project 2004 costs two years using the annualized 3.1% fee-for-service trend discussed in Section III, yielding a total trend adjustment of 6.2%.

3 Divide the projected rates by a target administration, and risk factor to develop a capitation rate. We used a factor of 6.25% for the four larger CMOs and 11.25% for Richland. Richland is smaller than the other CMOs and began operations one year later; in addition, as a smaller plan, there is increased risk of volatility in its delivery care patterns. Richland has about 35% of the enrollment of the next larger CMO, and about 20% of the enrollment of the second largest CMO (Milwaukee is the largest). Consequently, Richland has a much smaller base over which it can spread its administrative expenses, has had one less year to develop infrastructure and is subject to greater risk fluctuation than the other CMOs. The 6.25% factor is based on a review of CMO reported administrative costs in 2004 and year-to-date 2005.

4 Non-MA rates are developed using the county specific MA rates and the relative difference in comprehensive per capita costs between the two populations. Using the 2004 cost and eligibility data, aggregate PMPM costs were calculated for each population. The aggregate non-MA PMPM was 96.6% of the MA rate. However, due to the minimal size of the non-MA population, the square root of the ratio (98.3%) was used to estimate the non-MA rate. The final non-MA rates are calculated by applying this ratio uniformly to the county specific MA rates.

We adjusted both sets of rates (MA and non-MA) for cost-sharing to produce preliminary net rates from the gross cost projection. The estimate is based on the most recent Family Care data available and will be adjusted to actual individually calculated cost share amounts at the end of the contract year.

The final 2006 composite rates were calculated by combining the MA and non-MA rates using projected 2006 CMO exposure; as provided by the State.

Exhibit III-1 shows the projection of rates to 2006, the cost-sharing adjustment, the calculation of composite rates, and the resulting rate change versus the 2005 rates. In setting the final 2006 capitation rates, the Administration assumed a 'rate floor' equal to the prior year rate. This ensures CMOs no rate decrease from the final 2005 capitation rates.

V. ACTUARIAL CERTIFICATION

Following is our actuarial certification for the 2006 capitation rates

Actuarial Certification of
Proposed 2006 Family Care Capitated Rates
State of Wisconsin Department of Health and Family Services

I, Martin E. Staehlin, am associated with the firm of PricewaterhouseCoopers. I am a member of the American Academy of Actuaries and meet its Qualification Standards to certify as to the actuarial soundness of the 2006 capitation rates developed for the Medicaid managed care programs known as Family Care. I have been retained by the Wisconsin Department of Health and Family Services (DHFS) to perform an actuarial certification of the Family Care capitation rates for calendar year 2006 for filing with the Centers for Medicare and Medicaid Services (CMS). I have reviewed the capitation rates developed by DHFS and am familiar with the Code of Federal Regulations, 42 CFR 438.6(c) and the CMS "Appendix A, PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting."

I have examined the actuarial assumptions and actuarial methods used by DHFS in setting the capitation rates for calendar year 2006.

To the best of my information, knowledge and belief, for the period from January 1, 2006 to December 31, 2006, the capitation rates offered by DHFS are in compliance with 42 CFR 438.6(c), with respect to the development of Medicaid managed care capitation rates. The attached actuarial report describes the rate development methodology used by DHFS. I believe that the capitation rates have been developed in accordance with generally accepted actuarial principles and practices, and are appropriate for the populations to be covered and the services to be furnished under the contract. The capitation rates are based solely on the projected costs for State Plan services.

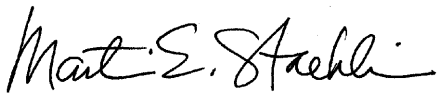
In making my opinion, I have relied upon the accuracy of the underlying enrollment, encounter, and other data and summaries prepared by DHFS and the participating contracted CMOs. A copy of the reliance letter received from DHFS is attached and constitutes part of this opinion. I reviewed the data for reasonableness; however, I performed no independent verification and take no responsibility as to the accuracy of these data.

The proposed actuarially sound rates shown are a projection of future events. It may be expected that actual experience will vary from the values shown here. Actuarial methods, considerations, and analyses used in developing the proposed capitation rates conform to the appropriate Standards of Practice promulgated from time to time by the Actuarial Standards Board.

The capitation rates may not be appropriate for any specific CMO. Each CMO will need to review the rates in relation to the benefits provided. The CMOs should compare the rates with their own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the State. The CMO may require rates above, equal to, or below the proposed actuarially sound capitation rates.

This Opinion assumes the reader is familiar with the Family Care program, eligibility rules, and actuarial rating techniques. The Opinion is intended for the State of Wisconsin and Centers for

Medicare and Medicaid Services and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial rate projections of the type in this Opinion, so as to properly interpret the projection results.



Martin E. Staehlin
Member, American Academy of Actuaries

January 18, 2005
Date

Exhibits

Wisconsin Department of Health and Family Services
CY 2006 Family Care Capitation Rate Development

Summary of 2004 Actual Experience by County (MA Comprehensives Only)

	MA Comprehensives Only											
	Fond du Lac		La Crosse		Milwaukee		Portage		Richland		All Counties	
	Elderly	Disabled	Elderly	Disabled	Elderly	Disabled	Elderly	Disabled	Elderly	Disabled	Elderly	Disabled
Exposure Months	5,330	5,328	6,630	10,696	59,576	309	4,238	3,956	1,395	1,858	77,169	22,148
Adaptive Equipment	29.29	41.59	72.65	98.09	66.12	112.98	45.44	71.58	43.16	47.99	62.59	75.77
Adult Day Activities	44.37	191.60	26.83	136.31	69.20	68.65	48.27	307.17	23.83	66.99	61.87	173.37
Case Management	232.01	279.30	240.63	264.79	301.75	300.02	239.94	302.25	329.09	311.68	288.78	279.40
Community At Large	-	-	-	-	-	-	-	-	-	-	-	-
Room and Board	(185.25)	(159.31)	(120.07)	(111.96)	(131.88)	(96.99)	(219.24)	(140.17)	(61.70)	(87.01)	(138.08)	(126.09)
Family Support Funding	-	-	-	-	-	-	-	-	-	-	-	-
Habilitation / Health	9.36	10.83	25.06	71.65	10.40	4.88	11.06	15.33	21.84	49.01	11.83	44.13
Home Care	134.11	369.99	164.59	320.61	345.55	430.60	439.82	1,327.11	548.05	426.23	324.24	522.67
Home Health Care	23.17	36.95	124.12	236.73	233.51	292.80	10.09	21.02	25.04	11.36	193.55	132.01
Housing	0.53	7.46	4.34	2.98	0.39	-	2.73	7.23	12.04	3.57	1.08	4.83
Institutional	285.99	62.41	568.03	164.18	282.37	101.01	368.12	94.62	644.95	132.92	318.43	123.77
Member Tracking	-	-	-	-	-	-	-	-	-	-	-	-
Other	5.25	5.83	0.02	-	1.01	0.18	1.53	4.02	1.03	1.22	1.25	2.23
Residential Care	1,045.51	907.71	522.04	593.15	577.17	626.15	824.66	764.63	261.59	647.68	612.67	704.49
Respite Care	5.33	19.79	18.80	54.27	0.97	-	14.14	59.51	2.28	42.65	3.55	45.18
Transportation	32.11	75.42	22.07	86.12	38.04	29.37	27.65	35.49	13.93	25.41	35.25	68.62
Vocational	11.19	228.12	4.12	178.11	10.90	31.07	8.09	215.45	7.05	149.21	10.11	192.33
Total	1,672.96	2,077.69	1,673.21	2,095.02	1,805.51	1,900.73	1,822.30	3,085.25	1,872.19	1,828.91	1,787.11	2,242.69
Composite PMPM	1,875.29		1,933.62		1,806.00		2,432.02		1,847.47		1,888.71	

Wisconsin Department of Health and Family Services
CY 2006 Family Care Capitation Rate Development

Summary of 2004 Actual Experience by County (All Recipients)

	All Recipients											
	Fond du Lac		La Crosse		Milwaukee		Portage		Richland		All Counties	
	Elderly	Disabled	Elderly	Disabled	Elderly	Disabled	Elderly	Disabled	Elderly	Disabled	Elderly	Disabled
Exposure Months	5,693	5,559	7,233	11,625	62,898	338	4,421	4,280	1,561	1,993	81,806	23,796
Adaptive Equipment	28.45	40.97	70.51	94.26	64.22	107.89	46.10	67.68	40.36	45.36	60.85	73.13
Adult Day Activities	41.59	185.79	24.72	126.75	66.67	62.67	46.41	284.77	21.30	62.48	59.25	162.67
Case Management	227.58	278.26	237.22	261.73	299.41	301.88	238.57	296.82	325.37	306.87	286.12	276.26
Community At Large	-	-	-	-	-	-	-	-	-	-	-	-
Room and Board	(174.53)	(153.36)	(111.05)	(103.63)	(128.41)	(90.16)	(213.69)	(129.88)	(58.72)	(81.12)	(133.37)	(117.89)
Family Support Funding	-	-	-	-	-	-	-	-	-	-	-	-
Habilitation / Health	8.99	11.76	25.07	69.57	10.19	4.62	10.66	14.69	19.70	45.83	11.63	43.28
Home Care	132.71	361.58	161.40	304.12	337.21	406.27	429.44	1,240.86	524.34	410.10	315.99	496.36
Home Health Care	23.17	37.33	118.51	220.52	224.03	268.09	9.99	20.02	22.80	10.60	185.31	124.75
Housing	0.49	7.15	4.09	2.91	0.49	-	3.07	6.72	10.76	3.33	1.15	4.58
Institutional	279.47	60.56	560.16	151.28	274.30	92.22	354.60	88.30	593.74	123.93	310.36	115.63
Member Tracking	-	-	-	-	-	-	-	-	-	-	-	-
Other	4.94	5.70	0.02	-	0.96	1.24	1.47	3.82	0.92	1.46	1.18	2.16
Residential Care	1,026.91	871.13	516.27	552.87	561.75	586.57	846.88	708.06	261.01	603.87	599.77	659.89
Respite Care	4.99	18.97	17.29	50.47	0.97	-	13.56	55.00	2.06	39.77	3.40	42.31
Transportation	31.22	73.23	21.06	81.27	37.02	28.10	27.27	33.32	13.02	24.11	34.22	65.22
Vocational	10.48	219.89	3.78	168.61	10.38	28.37	7.75	204.65	6.30	143.87	9.58	183.01
Total	1,646.45	2,018.95	1,649.04	1,980.73	1,759.20	1,797.76	1,822.06	2,894.84	1,782.94	1,740.45	1,745.47	2,131.35
Composite PMPM	1,830.48		1,853.51		1,759.41		2,349.75		1,759.11		1,832.42	

Wisconsin Department of Health and Family Services
CY 2006 Family Care Capitation Rate Development

Functional Screen Regression Model of 2004 PMPM
Comprehensive MAs Only

Variable	Estimate	p-Value	Incremental Partial R2	Proportion with Variable	Incremental Increase
Intercept (Grid Component)	750.16	0.0001			750
County (Grid Component)					
Richland	(60.01)	0.0047	0.00002	0.0328	(1.97)
La Crosse	(47.98)	0.0001	0.00001	0.1731	(8.31)
Fond du Lac	(264.66)	0.0001	0.00002	0.1069	(28.29)
Portage	82.45	0.0001	0.00460	0.0800	6.60
DD/NH Level of Care (Grid Component)					
DD1A	827.95	0.0001	0.01365	0.0103	8.52
DD1B	1,412.14	0.0001	0.04870	0.0202	28.47
DD2	858.10	0.0001	0.05359	0.1188	101.92
SNF	179.19	0.0001	0.06899	0.2112	37.84
Number of IADLs (Grid Component)					
IADL_3	118.53	0.0001	0.00980	0.1973	23.39
IADL_4	245.51	0.0001	0.00009	0.3471	85.21
IADL_5	379.73	0.0001	0.04740	0.2207	83.81
IADL_6	1,007.33	0.0001	0.04801	0.0325	32.72
Specific ADLs / Equipment Used (Add-On)					
Bathing_2	262.95	0.0001	0.04022	0.4533	119.18
Dressing_2	125.06	0.0001	0.01627	0.2502	31.29
Toileting_1	170.99	0.0001	0.00107	0.1590	27.19
Toileting_2	354.52	0.0001	0.01408	0.1628	57.72
Transfer_2	203.26	0.0001	0.00169	0.1492	30.32
Interaction Terms (Add-On)					
Dressing_Toileting	104.67	0.0001	0.00201	0.3986	41.73
Bathing_Equip_Dressing	154.08	0.0001	0.00265	0.3780	58.24
Transfer_Equip_Mobility	473.33	0.0001	0.00280	0.0424	20.09
Bathing_Equip_Eating	123.87	0.0001	0.00075	0.1554	19.25
Behavioral Variables (Add-On)					
Injury	275.04	0.0001	0.00233	0.0457	12.56
Offensive	296.15	0.0001	0.00379	0.1105	32.73
Medication Use (Add-On)					
Meds_2A	332.53	0.0001	0.00022	0.1966	65.39
Meds_2B	567.99	0.0001	0.01299	0.3611	205.11

Wisconsin Department of Health and Family Services
CY 2006 Family Care Capitation Rate Development

Summary of Proportion of CMO Population with Rating Characteristics
Comprehensive MAs Only

Variable	Fond Du Lac	La Crosse	Milwaukee	Portage	Richland
Disability or Nursing Home					
DD1A	1.6%	2.2%	0.7%	1.4%	3.0%
DD1B	6.3%	5.8%	0.4%	6.2%	5.4%
DD2	25.7%	19.3%	5.4%	19.1%	20.5%
SNF	22.6%	19.0%	26.3%	18.7%	14.4%
Instrumental Activities of Daily Living					
IADL_3	15.1%	19.3%	20.2%	15.5%	20.5%
IADL_4	29.2%	27.8%	39.5%	30.3%	27.5%
IADL_5	30.4%	20.2%	22.1%	28.7%	17.8%
IADL_6	10.5%	6.8%	0.7%	5.7%	6.4%
Activities of Daily Living					
Bathing_2	46.0%	38.1%	52.3%	46.5%	30.9%
Dressing_2	24.7%	21.7%	30.9%	27.3%	16.4%
Toileting_1	14.7%	13.8%	17.8%	17.7%	16.1%
Toileting_2	18.4%	16.3%	19.2%	18.6%	14.4%
Transfer_2	16.2%	14.1%	18.3%	16.2%	10.4%
Interaction Terms					
Dressing_Toileting	40.5%	36.2%	50.2%	45.8%	34.2%
Bathing_Equip_Dressing	38.1%	36.3%	48.6%	44.5%	30.5%
Transfer_Equip_Mobility	7.6%	8.8%	7.7%	7.5%	7.4%
Bathing_Equip_Eating	20.1%	18.8%	18.7%	25.7%	16.4%
Behavioral Variables					
Injury	7.5%	5.5%	3.3%	7.0%	6.7%
Offensive	21.4%	13.5%	8.7%	17.6%	13.1%
Medication Use					
Meds_2A	16.2%	21.1%	22.1%	22.1%	18.8%
Meds_2B	46.8%	30.4%	40.7%	36.9%	27.5%

Wisconsin Department of Health and Family Services
CY 2006 Family Care Capitation Rate Development

Annual Eligibility Summary - Comprehensive

MMIS

	CY 2000	CY 2001	CY 2002	CY 2003	CY 2004
Eligible Days					
Elderly	2,371,218	2,483,998	2,788,771	2,846,144	2,432,879
Disabled	3,340,868	3,494,177	3,836,186	4,064,471	3,866,419
Total MMIS Days	5,712,086	5,978,175	6,624,957	6,910,615	6,299,298
Percent of Total					
Elderly	41.51%	41.55%	42.09%	41.19%	38.62%
Disabled	58.49%	58.45%	57.91%	58.81%	61.38%
Total	100.00%	100.00%	100.00%	100.00%	100.00%

HSRS

	CY 2000	CY 2001	CY 2002	CY 2003	CY 2004
Eligible Days					
Elderly	2,305,732	2,384,493	2,709,290	2,778,035	2,400,872
Disabled	3,316,256	3,458,033	3,791,008	4,030,851	3,871,545
Total MMIS Days	5,621,988	5,842,526	6,500,298	6,808,886	6,272,417
Percent of Total					
Elderly	41.01%	40.81%	41.68%	40.80%	38.28%
Disabled	58.99%	59.19%	58.32%	59.20%	61.72%
Total	100.00%	100.00%	100.00%	100.00%	100.00%

Wisconsin Department of Health and Family Services
CY 2006 Family Care Capitation Rate Development

Development of Projected Trends; Comprehensive - Total

MMIS

	2004 PMPM	2004-2005 Reimbursement Trend	2004-2005 Mix / Utilization Trend	Projected 2005 PMPM	2005-2006 Reimbursement Trend	2005-2006 Mix / Utilization Trend	Projected 2006 PMPM
Nursing Facility	82.66	0.00%	0.60%	83.16	0.00%	0.60%	83.66
MR Centers	11.12	0.00%	0.60%	11.18	0.00%	0.60%	11.25
MR Facilities	4.86	0.00%	0.60%	4.89	0.00%	0.60%	4.92
Home Care	467.00	0.00%	0.60%	469.81	0.00%	0.60%	472.63
Case Management	0.30	0.00%	0.60%	0.31	0.00%	0.60%	0.31
Other [(1)]	70.55	0.00%	0.60%	70.97	0.00%	0.60%	71.39
MMIS Total	636.49			640.31			644.15

HSRS

	2004 PMPM	2004-2005 Reimbursement Trend	2004-2005 Mix / Utilization Trend	Projected 2005 PMPM	2005-2006 Reimbursement Trend	2005-2006 Mix / Utilization Trend	Projected 2006 PMPM
Habilitation	9.35	0.00%	3.80%	9.71	0.00%	3.80%	10.07
Home Care	544.39	0.00%	3.80%	565.07	0.00%	3.80%	586.55
Residential	762.46	0.00%	3.80%	791.44	0.00%	3.80%	821.51
Case Management	157.22	0.00%	3.80%	163.19	0.00%	3.80%	169.39
Other [(2)]	625.26	0.00%	3.80%	649.02	0.00%	3.80%	673.68
Cost Sharing	(11.21)	0.00%	3.80%	(11.63)	0.00%	3.80%	(12.07)
HSRS Total	2,087.47			2,166.79			2,249.13
Total MMIS & HSRS	2,723.96			2,807.10			2,893.28
Two-Year Trend							6.2%
Annual Trend				3.1%			3.1%

Wisconsin Department of Health and Family Services
CY 2006 Family Care Capitation Rate Development

Development of Projected Trends; Comprehensive - Elderly

MMIS

	2004 PMPM	2004-2005 Reimbursement Trend	2004-2005 Mix / Utilization Trend	Projected 2005 PMPM	2005-2006 Reimbursement Trend	2005-2006 Mix / Utilization Trend	Projected 2006 PMPM
Nursing Facility	174.77	0.00%	0.70%	176.00	0.00%	0.70%	177.23
MR Centers	-	0.00%	0.70%	-	0.00%	0.70%	-
MR Facilities	2.32	0.00%	0.70%	2.34	0.00%	0.70%	2.36
Home Care	258.84	0.00%	0.70%	260.65	0.00%	0.70%	262.48
Case Management	0.26	0.00%	0.70%	0.26	0.00%	0.70%	0.26
Other [1]	53.39	0.00%	0.70%	53.76	0.00%	0.70%	54.14
MMIS Total	489.58			493.01			496.46

HSRS

	2004 PMPM	2004-2005 Reimbursement Trend	2004-2005 Mix / Utilization Trend	Projected 2005 PMPM	2005-2006 Reimbursement Trend	2005-2006 Mix / Utilization Trend	Projected 2006 PMPM
Habilitation	5.90	0.00%	6.40%	6.27	0.00%	6.40%	6.67
Home Care	414.74	0.00%	6.40%	441.29	0.00%	6.40%	469.53
Residential	555.09	0.00%	6.40%	590.61	0.00%	6.40%	628.41
Case Management	143.29	0.00%	6.40%	152.46	0.00%	6.40%	162.22
Other [2]	169.22	0.00%	6.40%	180.05	0.00%	6.40%	191.58
Cost Sharing	(19.06)	0.00%	6.40%	(20.28)	0.00%	6.40%	(21.58)
HSRS Total	1,269.18			1,350.41			1,436.83
Total MMIS & HSRS	1,758.76			1,843.41			1,933.29
Two-Year Trend							9.9%
Annual Trend				4.8%			4.9%

Wisconsin Department of Health and Family Services
CY 2006 Family Care Capitation Rate Development

Development of Projected Trends; Comprehensive - Disabled

MMIS

	2004 PMPM	2004-2005 Reimbursement Trend	2004-2005 Mix / Utilization Trend	Projected 2005 PMPM	2005-2006 Reimbursement Trend	2005-2006 Mix / Utilization Trend	Projected 2006 PMPM
Nursing Facility	24.71	0.00%	0.20%	24.76	0.00%	0.20%	24.81
MR Centers	18.11	0.00%	0.20%	18.15	0.00%	0.20%	18.19
MR Facilities	6.45	0.00%	0.20%	6.46	0.00%	0.20%	6.48
Home Care	597.99	0.00%	0.20%	599.19	0.00%	0.20%	600.38
Case Management	0.33	0.00%	0.20%	0.33	0.00%	0.20%	0.33
Other [(1)]	81.34	0.00%	0.20%	81.50	0.00%	0.20%	81.67
MMIS Total	728.94			730.39			731.86

HSRS

	2004 PMPM	2004-2005 Reimbursement Trend	2004-2005 Mix / Utilization Trend	Projected 2005 PMPM	2005-2006 Reimbursement Trend	2005-2006 Mix / Utilization Trend	Projected 2006 PMPM
Habilitation	11.42	0.00%	2.60%	11.72	0.00%	2.60%	12.02
Home Care	622.10	0.00%	2.60%	638.27	0.00%	2.60%	654.87
Residential	886.77	0.00%	2.60%	909.83	0.00%	2.60%	933.48
Case Management	165.56	0.00%	2.60%	169.87	0.00%	2.60%	174.28
Other [(2)]	898.62	0.00%	2.60%	921.98	0.00%	2.60%	945.95
Cost Sharing	(6.50)	0.00%	2.60%	(6.67)	0.00%	2.60%	(6.84)
HSRS Total	2,577.97			2,645.00			2,713.77
Total MMIS & HSRS	3,306.91			3,375.39			3,445.62
Two-Year Trend							4.2%
Annual Trend				2.1%			2.1%

Wisconsin Department of Health and Family Services
CY 2006 Family Care Capitation Rate Development

Annual PMPM Summary; Comprehensive - Total

MMIS PMPM

	CY 2000	CY 2001	CY 2002	CY 2003	CY 2004	2000 - 2004 Trend
Nursing Facility	91.92	96.52	101.78	95.64	82.66	-2.62%
MR Centers	13.20	12.92	9.59	16.71	11.12	-4.19%
MR Facilities	9.85	13.58	13.89	12.78	4.86	-16.21%
Home Care	359.39	406.04	395.36	407.07	467.00	6.77%
Case Management	1.44	1.70	1.55	1.39	0.30	-32.26%
Other [(1)]	72.76	70.14	70.41	70.23	70.55	-0.77%
MMIS Total	548.56	600.89	592.58	603.81	636.49	3.79%

HSRS PMPM

	CY 2000	CY 2001	CY 2002	CY 2003	CY 2004	2000 - 2004 Trend
Habilitation	5.86	5.88	6.51	7.21	9.35	12.39%
Home Care	646.70	644.61	610.78	590.61	544.39	-4.21%
Residential	566.29	620.54	667.32	708.56	762.46	7.72%
Case Management	139.28	147.52	154.16	162.17	157.22	3.07%
Other [(2)]	418.11	460.87	485.01	524.93	625.26	10.58%
Cost Sharing	(9.45)	(9.06)	(10.60)	(11.89)	(11.21)	4.36%
HSRS Total	1,766.79	1,870.35	1,913.18	1,981.59	2,087.47	4.26%

Wisconsin Department of Health and Family Services
CY 2006 Family Care Capitation Rate Development

Annual PMPM Summary; Comprehensive - Elderly

MMIS PMPM

	CY 2000	CY 2001	CY 2002	CY 2003	CY 2004	2000 - 2004 Trend
Nursing Facility	166.49	182.93	181.99	174.49	174.77	1.22%
MR Centers	0.27	-	0.07	3.92	-	-100.00%
MR Facilities	3.02	4.10	2.33	5.60	2.32	-6.39%
Home Care	201.27	222.73	209.65	216.72	258.84	6.49%
Case Management	1.24	1.61	1.32	1.09	0.26	-32.60%
Other [(1)]	47.31	48.24	47.66	49.49	53.39	3.07%
MMIS Total	419.61	459.61	443.00	451.30	489.58	3.93%

HSRS PMPM

	CY 2000	CY 2001	CY 2002	CY 2003	CY 2004	2000 - 2004 Trend
Habilitation	2.98	2.96	3.15	3.86	5.90	18.63%
Home Care	428.51	423.26	403.97	401.74	414.74	-0.81%
Residential	309.97	349.00	436.86	489.51	555.09	15.68%
Case Management	120.56	127.94	134.19	146.03	143.29	4.41%
Other [(2)]	124.00	131.67	135.87	146.12	169.22	8.08%
Cost Sharing	(10.84)	(12.44)	(16.52)	(18.65)	(19.06)	15.15%
HSRS Total	975.18	1,022.40	1,097.51	1,168.61	1,269.18	6.81%

Wisconsin Department of Health and Family Services
CY 2006 Family Care Capitation Rate Development

Annual PMPM Summary; Comprehensive - Disabled

MMIS PMPM

	CY 2000	CY 2001	CY 2002	CY 2003	CY 2004	2000 - 2004 Trend
Nursing Facility	39.00	35.09	43.47	40.42	24.71	-10.78%
MR Centers	22.37	22.10	16.52	25.66	18.11	-5.14%
MR Facilities	14.70	20.31	22.30	17.81	6.45	-18.61%
Home Care	471.61	536.35	530.37	540.37	597.99	6.12%
Case Management	1.59	1.76	1.72	1.59	0.33	-32.27%
Other [(1)]	90.83	85.71	86.95	84.75	81.34	-2.72%
MMIS Total	640.09	701.33	701.32	710.61	728.94	3.30%

HSRS PMPM

	CY 2000	CY 2001	CY 2002	CY 2003	CY 2004	2000 - 2004 Trend
Habilitation	7.75	7.75	8.77	9.43	11.42	10.18%
Home Care	789.72	786.48	749.93	716.01	622.10	-5.79%
Residential	734.30	794.59	822.38	854.00	886.77	4.83%
Case Management	151.55	160.08	167.60	172.89	165.56	2.24%
Other [(2)]	610.89	671.87	719.92	776.46	898.62	10.13%
Cost Sharing	(8.54)	(6.89)	(6.61)	(7.41)	(6.50)	-6.58%
HSRS Total	2,285.66	2,413.87	2,461.98	2,521.39	2,577.97	3.05%

Wisconsin Department of Health and Family Services
CY 2006 Family Care Capitation Rate Development

2006 Rates Developed from Final 2005 Capitation Rates - Intermediate

	Intermediate Composite Rate		
Target Group	**2005 Rate**	**2005 Trend**	**2006 Rate**
Statewide	$ 691.35	0.00%	$ 691.35

Wisconsin Department of Health and Family Services
CY 2006 Family Care Capitation Rate Development

Development of the 2006 Final Rates

County	Total Statistical Model 2004 PMPM Inc IBNR	Administration and Risk Add-On	Two-Year Trend	2006 Gross MA Rates	Sqrt of Ratio (non-MA to MA) from Special Populations	Final 2006 Gross Non-MA Rates
Fond du Lac	1,956.05	93.75%	6.2%	2,216.15	0.983	2,178.21
La Crosse	1,844.42	93.75%	6.2%	2,089.68	0.983	2,053.90
Milwaukee	1,870.46	93.75%	6.2%	2,119.17	0.983	2,082.89
Portage	2,177.67	93.75%	6.2%	2,467.23	0.983	2,424.99
Richland	1,824.68	88.75%	6.2%	2,183.77	0.983	2,146.38

	2006 Projected Exposure		2006 Ave. Cost Sharing PMPM		Final 2006 Net Rates	
County	MA	Non-MA	MA	Non-MA	MA	Non-MA
Fond du Lac	11,478	199	50.35	497.38	2,165.80	1,680.83
La Crosse	19,915	415	61.26	315.52	2,028.42	1,738.37
Milwaukee	68,857	761	68.31	463.84	2,050.86	1,619.05
Portage	10,319	113	50.13	595.79	2,417.10	1,829.20
Richland	3,564	106	51.72	3.08	2,132.05	2,143.30

County	Preliminary 2006 Net Composite Rates	Final 2006 Capitation Rates	Final 2005 Capitation Rates	Net Rate Change 2006 vs. 2005
Fond du Lac	2,157.53	2,157.53	2,120.74	1.7%
La Crosse	2,022.50	2,022.50	1,828.82	10.6%
Milwaukee	2,046.14	2,055.01	2,055.01	0.0%
Portage	2,410.74	2,410.74	2,320.75	3.9%
Richland	2,132.37	2,140.30	2,140.30	0.0%